State Health Planning and Development Agency
1177 Alakea St. #402 Honolulu, Hawaii 96813
Phone: 808-587-0852 FAX: 808-587-0783 Email: survey@shpda.org Web: www.shpda.org

Utilization Report
For the Period of January 1 to December 31, 2003

Facility:			
Name of Administrator:			
Completed by: (signature)		Phone:	
(print/type name)		FAX:	
(title)		Email:	

Type of Beds	Total Certificate Approved Beds (A)	Total Licensed Beds (B)	Total Staffed Beds (C)	If Col. C is Less Than Col. B, Give Reason(s) For Not Staffing All Beds (D)	Total Inpatient Days (E)	Total Admissions (F)
Acute Care Beds:						
Medical/Surgical						
Critical Care						
Obstetric						
Pediatric						
Neonatal ICU						
Psychiatric (Psych)						
Long Term Care Beds:						
Skilled Nursing (SNF)						
Intermediate Care (ICF)						
SNF/ICF						
Acute/SNF						
Special/Other Beds:						
Psychiatric (spec.)						
Tuberculosis (TB)						
Mentally Retarded (MR)						
SNF/ICF MR						
Hansen's Disease						
Rehabilitation						
Children's Orthopedic						
Medical/Surgical-spec						
Other(s) (specify):						

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Name of Facility: Date:

Type of Beds	Daily Room Rates on December 31, 2003			
	Private	Semi-Private	Ward	Other(s) (specify):
Acute Care Beds:				
Medical/Surgical				
CCU				
ICU				
Neonatal ICU				
OB - Labor/Delivery				
OB - Mother's Room				
OB - Nursery				
Pediatric				
Psychiatric (Psych)				
Other(s) (specify):				
Long Term Care Beds:				
SNF				
ICF				
Psychiatric (Psych)				
Tuberculosis (TB)				
Mentally Retarded (MR)				
Rehabilitation				
Children's Orthopedic				
Hansen's Disease				
Other(s) (specify):				
Special Treatment Beds:				
(specify):				

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Name of Facility: Date:

TABLE 1. WAIT LISTED PATIENTS IN ACUTE CARE BEDS READY TO DISCHARGE BUT UNABLE TO PLACE
(for completion by facilities with acute care beds)

Type of Facility Wait Listed To	SNF/ICF (A)	Care Homes & Alternatives Such as NHWW, Project Malama, etc. (B)	Home Health, Day Hospital, Day Care (C)	Other(s) (specify): _____ _____ _____ (D)	Total Col (A+B+C+D) (E)
On the last day of the reporting period enter the number of patients wait listed for:					

Reasons for Wait Listing	Beds Were Not Avail-able (F)	Psychiatric, Dementia, Behavior, etc. Problem(s) (G)	Special Services/ Care Required (H)	Financial, Medicaid, Insurance, etc. Problem(s) (I)	Family/ Caregiver/ Guardianship Problem(s) (J)	Pending PASARR Screening (K)	Other(s) Specify: _____ _____ _____ (L)
On the last day of the reporting period the number of patients that were wait listed because of the following primary reasons were as follows:							

During the Reporting Period:

(1) The total number of wait listed patients in acute care beds was: _____ patients.
(2) The total patient days attributed to wait listed patients in acute care beds was: _____ patient days.
(3) Were your wait listed patients included in your acute care bed utilization data totals on page 1? ☐ Included ☐ Excluded

TABLE 2. WAIT LISTED PATIENTS IN LONG TERM CARE BEDS READY TO DISCHARGE BUT UNABLE TO PLACE
(for completion by facilities with long term care beds)

Type of Facility Wait Listed To	SNF/ICF (A)	Care Homes & Alternatives Such as NHWW, Project Malama, etc. (B)	Home Health, Day Hospital, Day Care (C)	Other(s) (specify): _____ _____ _____ (D)	Total Col (A+B+C+D) (E)
On the last day of the reporting period enter the number of patients wait listed for:					

Reasons for Wait Listing	Beds Were Not Avail-able (F)	Psychiatric, Dementia, Behavior, etc. Problem(s) (G)	Special Services/ Care Required (H)	Financial, Medicaid, Insurance, etc. Problem(s) (I)	Family/ Caregiver/ Guardianship Problem(s) (J)	Pending PASARR Screening (K)	Other(s) Specify: _____ _____ _____ (L)
On the last day of the reporting period the number of patients that were wait listed because of the following primary reasons were as follows:							

During the Reporting Period:

(1) The total number of wait listed patients in long term care care beds was: _____ patients.
(2) The total patient days attributed to wait listed patients in long term care beds was: _____ patient days.
(3) Were your wait listed patients included in your long term care bed utilization data totals on page 1? ☐ Included ☐ Excluded

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Equipment/Procedures Utilization Report
For January 1 to December 31, 2003

Facility: Phone:
Completed by: (signature) FAX:
(print/type name) Email:
(title)

Equipment Currently Available By Make/Model (including upgrades)	*Account for all equipment/procedures in your facility.* Year Acquired	Years of Useful Life Remaining	Cost of Purchase or Upgrade	Total Number of Procedures Completed	Average Professional Charge Per Procedure	Average Technical Charge Per Procedure
Computed Tomography (CT)						
General Radiology						
Ultrasound Equipment						
Nuclear Medicine Equipment						
Angiography						
Mammography						
Positron Emission Tomography (PET)						
Lithotripsy Unit						
Gamma Knife						

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Radiation Therapy Utilization Report
For January 1 to December 31, 2003

Facility:	Phone:
Completed by: (signature)	FAX:
(print/type name)	Email:
(title)	

Radiation Therapy Currently Available By Make/Model (including upgrades)	*Account for all equipment/procedures in your facility.* Year Acquired	Years of Useful Life Remaining	Cost of Purchase or Upgrade

Radiation Therapy	For the Reporting Period
Total Number of Cases (Unduplicated Patient Counts)	
Total Number of Treatments (A treatment is a single patient visit equivalent)	
Average Professional Charge Per Treatment	
Average Technical Charge Per Treatment	

Total Number of Patients Seen From (Patient Origin)	For the Reporting Period
O`ahu	
Hawai`i	
Kaua`i	
Maui	
Lana`i	
Moloka`i	
Other	
Unknown/Missing	

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Services/Procedures Utilization Report
For January 1 to December 31, 2003

Facility: Phone:
Completed by: (signature) FAX:
(print/type name) Email:
(title)

Services	*Account for all services/procedures in your facility.* Unit of Measurement	Please Enter Your January 1 to December 31, 2003 Utilization
Hemodialysis	total number of stations	
	total number of treatments	
Adult Cardiac Catheterization	number of diagnostic-equivalent cardiac catheterization procedures	
Pediatric Cardiac Catheterization	number of diagnostic-equivalent cardiac catheterization procedures	
Adult Open Heart Surgery	number of adult open-heart operations	
Pediatric Open Heart Surgery	number of pediatric open-heart operations	
All Other Operating Rooms: Inpatient Only (more than 24 hours stay)	number of hours per room utilization per year	
All Other Operating Rooms: Blended Inpatient/Outpatient (less than 24 hours stay)	number of hours per room utilization per year	
All Other Operating Rooms: Freestanding Ambulatory Surgery Center (less than 24 hours stay)	number of hours per room utilization per year	

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MRI Utilization Report

For the Period of January 1 to December 31, 2003

Facility Name: Phone:

Completed by:

(signature) FAX:

(print/type name) Email:

(title)

Account for all MRI equipment in your facility. Account for all MRI procedures in your facility.

Part A. MRI Unit(s)

Make/Model/Tesla (include upgrades)	Month/Year Acquired	Years of Useful Life Remaining	Cost of Purchase or Upgrade	Total Hours Operated During the Period	Total Hours Downtime During the Period

Part B. Charges and Utilization

Average Professional Charge (A)	Average Technical Charge (B)	Total Number of MRI Procedures Completed (C)	Total Number of MRI Sequences Completed (D)	Total Number of Negative Scans (E)

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Part C. Patient Origin and Type

Patients Seen From (Patient Origin)	Total Number of Inpatients	Total Number of Outpatients
O`ahu		
Hawai'i		
Kaua'i		
Maui		
Lana'i		
Moloka'i		
Other		
Unknown/Missing		

Part D. Financial Statements

Please submit a copy of your Income Statement, and Statement of Revenues and Expenses for the corresponding period.

Part E. Fee Schedules

Please submit a copy of your current fee schedules.

Please return your completed survey form, file or diskette by June 30, 2004 to:

State Health Planning and Development Agency

1177 Alakea St. #402

Honolulu, HI 96813

or *you may FAX your survey to SHPDA-MRI Survey at 587-0783*

or *you may Email your survey to* ***survey@shpda.org***

If you have any questions please call: Ken Yoshida at 587-0852 or 587-0788

Please note that this survey from may be altered after initial responses are reviewed to better suit the needs of the agency and to better facilitate the recordkeeping requirements of the providers.

Thank you for completing this MRI Survey.